FOOTNOTES

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[1]For dates of service beginning July 1, 2000, the 1999 Cost Report is the basis for reimbursement.

[2]If a facility remains in the same cost center grouping as in the previous year, and if the Maximum Percentile for that cost center grouping decreases while at least two-thirds of the facilities in the grouping experience increases in their Net Per Diem, the Allowed Per Diem for that particular cost center is equal to the Net Per Diem or the prior year's Standard Per Diem, whichever amount is less to the facility. Beginning November 1, 1981, this policy will not be applicable because of cost containment.

[3]In the case of the Property and Related Cost Center, a legitimate return on equity will be allowed. However, for any facility having a property transaction after May 6, 1981 but before June 15, 1983, (excluding leases for which the Division had approved rates on or before that date) the total Property and Related Net Per Diem, including return on equity, shall not exceed the Standard Per Diem. The property rate for any facility having a property transaction after June 14, 1983 will be subject to the provisions of Sections 1002.5(g) through (n). Effective November 1, 1991 and after, the Return on Equity is 0% for facilities not being reimbursed under the Dodge Index Formula (Sections 1002.5g-n). Effective July 1, 1994 and after, the Return on Equity is 0% for all facilities.

[4]Any projected costs approved by the Division in accordance with Section 1002.4 will be added to reported costs for computation of the Net Per Diem.

[5]See Section 1002.5 of the Nursing Home Manual for additional description of such limitations.

[6]For all State Institution Distinct Part Nursing Facilities, Level I Net Per Diem = (Historical Level I Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Level I Patient Days, Schedule A, Line 13, Column 6).

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ICF-MR Net Per Diem = (Historical ICF-MR Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total ICF-MR Patient Days, Schedule A, Line 13, Column 7).

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs.

[7]For a facility with a Property and Related Net Per Diem in excess of the Property and Related Standard Per Diem, the Net Per Diem will be reduced to the Standard Per Diem. This will remain in effect until the requirements of Section 1002.5 are complied with. After these requirements have been met, a retroactive adjustment in the Net Per Diem will be made where appropriate effective July 1, 2000. For any facility having a property transaction after May 6, 1981, (excluding leases for which the Division had approved rates on or before that date) the total Property and Related Net Per Diem, shall not exceed the Standard Per Diem.

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[8]The grouping will be done using Net Per Diem for each cost center that has been reported by the facility, and calculated by the Division on June 30, 2000. Standards effective July 1, 2000, will not be recalculated based upon changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or addition of projected cost as defined in Section 1002.4, or any change in the Net Per Diem in any cost center.

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[9]There are several instances where a facility could fall in more than one group. In these cases, the following rules apply:

a) Hospital-based Level II facilities are classified as hospital-based.

b) Hospital-based facilities with only intermediate level of care patients are classified as Level III facilities.

c) Intermediate care facilities for the mentally retarded which also are distinct part are classified as intermediate care facilities for the

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mentally retarded. See Footnotes 6 and 10 for separate treatment in Routine and Special Services cost centers.

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For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility it is as of June 30, 2000.

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If a facility changes classification to hospital-based or from Level III to Level II or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year. For further information on classification of nursing facilities, see Section 1006.

[10]For State Institution Distinct Part Nursing Facilities, a Level I Standard Per Diem will be calculated separately from an ICF/MR Standard Per Diem, using the Level I Net Per Diems and ICF/MR Net Per Diems, respectively. This applies only to the Routine and Special Services cost center. The standard per diems for other cost centers for Distinct Part State Facilities will be calculated using the ICF/MR Standard per diems.

[11]The age of the facilities as of October 1976. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.

[12]All property transactions defined in Section 1002.1(h) will be evaluated according to the provisions of HCFA-15-1, The Provider Reimbursement Manual. All transactions which are not found to be arms-length will result in reimbursement at the lesser of:

a) Actual cost to the Related Party

b) The property rate component calculated under Section 1002.5

Effective 7/1/95, this footnote will not apply.

[13]For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship, or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. In addition, if the transaction could have been reviewed under Section 1122 of the Social Security Act but was not, reimbursement will not be affected unless the Division determines that the transaction would have been approved.

[14]Initial transaction is the last lease, sale, or change of ownership between July 13, 1978 and October 1, 1980, if any, or the first lease, sale, or change of ownership after September 30, 1980, if none occurred between July 13, 1978 and October 1, 1980.

[15]Subsequent transaction is the most recent lease, sale, or change of ownership occurring within ten years of the initial transaction.

[16]Reasonable construction acquisition cost is determined as follows:

a) For all existing facilities, multiply the regional Dodge Construction Index from the April - September, 1982 issue for the calendar year preceding the prospective rate year by the average construction multiplier for Atlanta. For facilities less than 30,000 square feet the cost range of 20,000 - 30,000 square feet will be used and for facilities 30,000 square feet or greater the cost range will be based on the 30,000 - 40,000 square foot indicator. All facilities having their first property transaction after June 14, 1983 (i.e., newly constructed facilities) will use the 30,000 - 40,000 square foot range.

b) Multiply the product from 16.a. by 108%.

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c) Multiply the product from 16.b. by the gross square footage of the facility with a maximum of 300 square feet per bed allowed. (New facilities will use 300 square feet per bed regardless of actual square footage. Existing facilities will use actual footage up to the maximum allowable. New facilities for which a subsequent property transaction occurs will use actual square footage up to the maximum allowable).

d) Multiply the result of 16.c. by the depreciation factor. The depreciation factor is calculated by subtracting the age of the facility in years from 40 and dividing the result by 40. Where the facility is more than 20 years old, a value of 20. is used such that the facility is never more than 50% depreciated based on a 40 year life.

e) Multiply the result of 16.d. by an amortization factor which is determined according to the formula below:

$$\frac{1}{1/r \times [1-1/(1+r)^n]}$$

r represents the return rate[18] and n is the remaining years of life of the facility based on a 40 year life.

[17]Total Patient Days equals 90% of the maximum number of available patient days for a given facility per year.

[18]Return Rate - This percentage will be reviewed and set by the Division.

[19]The Division does not recognize the termination of a lease prior to its stated expiration date as a property transaction. It will be presumed that the termination of a lease prior to its stated expiration date was done to increase Medicaid reimbursement; provided, however, that the presumption is rebuttable if

the provider can demonstrate by clear and convincing evidence that the lease was terminated for some other legitimate purpose. In the event of the termination of a lease prior to its stated expiration date, the facility's Property and Related reimbursement rate will then be based upon historical costs or the Dodge Index Rate, whichever applies.

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[20]Facilities owned by the Georgia Department of Human Resources will be reimbursed at the rate determined by 1002.5(h) through (m) of this manual.

[21]Costs for property taxes and property insurance, as defined in the Uniform Chart of Accounts, are included but are not subject to the property and related cost center Standard Per Diem.

[22]See Section 1002.8 for the procedures to follow when a facility or other property is sold and depreciation costs reimbursed by the Division must be recaptured.

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[23]Effective August 16, 1996, Allowable Home Office salary costs are limited to an appropriate maximum.* Fringe benefits are also limited to an appropriate maximum.* (A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation.) Reimbursement for the cost of home office vehicle is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designated maximums.

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[24]Effective for dates of service April 1, 1991, per diem reimbursement rates for non-State nursing facilities were increased by $1.24 to include the costs associated with the minimum wage increase mandated by federal law. The minimum wage increased from $3.85 per hour to $4.25 per hour effective April 1, 1991. Because part of the costs for minimum wage increases are included in the 1991 cost report, effective for dates of service July 1, 1992, per diem reimbursement rates for non-State nursing facilities will be increased by $.93 to include the costs associated with the minimum wage increase mandated by federal law. For dates of service July 1, 1993, and after, there will be no adjustment for

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the minimum wage increase because the costs are already included in the 1992 cost report.

*Explanation for "appropriate maximum" in Footnote 23:

Home Office salaries and related fringe benefits are subjected to a $100,000 maximum salary for CEO, COO, CFO and other Home Office personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of $100,000 to be applied only to owners of nursing facilities and related parties.

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APPENDIX D

UNIFORM CHART OF ACCOUNTS, COST REPORTING AND REIMBURSEMENT PRINCIPLES

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report and the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are mailed to each facility prior to the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Health Care Financing Administration Manual-HCFA-15-1. Copies of the Manual, which provide a detailed description of allowable costs, are available from the Health Care Financing Administration of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing homes participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its accounting system

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differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing homes in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports may be mailed or hand-delivered to the Division. If mailed, it must be sent certified mail and be postmarked on or before September 30th. If hand-delivered, it must be received by the Division before the close of business on September 30th. (See Hospital-based facility exception in 2(d) below.)

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b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of $50.00 per day for the first thirty days and a penalty of $100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an

extension is obtained from the Division Director of Nursing Home Reimbursement Services prior to September 30.

c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.

d. Hospital-based facilities using Medicare fiscal year ending dates between January 30 and April 30 must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May 31 and June 30 must submit cost reports on or before November 30. Facilities using fiscal year ending dates between July 31 and September 30 must submit cost reports on or before December 31 using the most recent complete fiscal year cost data. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

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Approval for extensions beyond the November 30 or December 31 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross- referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree

with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable.

Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in HCFA-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

f. All nursing facilities are required to submit to the Division any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.

h. New facilities which have less than twelve but not less than six months of actual operating cost experience will only submit cost data for their actual months of operation as of June 30. New facilities which have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing

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the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

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For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data, with the appropriate Dodge Index property rate. If the new owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates, the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the HCFA-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.

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j. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay

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for travel costs incurred for any examination conducted at the out-of-state location.

k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate workpapers or letters of explanation should be attached.

l. All cost reports and correspondence concerning these cost reports are to be mailed to the following address:

Division of Medical Assistance
Nursing Home Reimbursement Section
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report.

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